Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS662HOS	A. BUILDING _____ B. WING _____	02/24/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMERLIN HOSPITAL MEDICAL CENTER	657 TOWN CENTER DRIVE LAS VEGAS, NV 89144

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments This Statement of Deficiencies was generated as the result of a complaint investigation survey conducted at your facility on 02/24/09. The state licensure survey was conducted in accordance with Chapter 449, Hospitals, adopted by the State Board of Health December 11, 1998 last amended September 27, 1999. There were six complaints investigated. Complaint # 15721 - Unsubstantiated Complaint # 21027 - Unsubstantiated Complaint # 16692 - Unsubstantiated Complaint # 20434 - Unsubstantiated Complaint # 18302 - Unsubstantiated Complaint # 17696 - Substantiated (Tag S0523 and SO153) The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws. The following regulatory deficiencies were identified.	S 000		
S 153 SS=D	NAC 449.332 Discharge Planning 11. The patient, members of the family of the patient and any other person involved in caring for the patient must be provided with such information as is necessary to prepare them for the post-hospital care of the patient. This Regulation is not met as evidenced by: Based on interview, record review and document review the facility failed to ensure members of the	S 153		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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S 153	Continued From page 1 family of the patient who were involved in the care of the patient were provided with information regarding the transfer and post-hospital care of the patient. (Patient #1) Finding Include: The patient was an 84 year old female admitted to the facility emergency room on 03/16/08 from an assisted living facility for a dislocation of the left shoulder following a fall. The patient's diagnoses included dementia. On 02/24/09 at 1:10 PM, The Chief Nurse indicated the patients transfer was turned over to an insurance plan. A physician at the insurance plan was responsible for providing discharge orders and instructions for the patients transfer. The Chief Nurse acknowledged due to the patients diagnosis of dementia the nurses in the emergency room were responsible for notifying the patients family of the discharge plan and the location of the facility the patient was transferred to. The Chief Nurse confirmed there was no documentation in the medical record that family members were notified of the patients discharge plan and transfer to another facility on 03/17/08. On 02-24-09 at 2:00 PM, the Associate Director of the Emergency Department indicated the patients care was transferred to a hospitalist who was responsible for handling the patients transfer orders and discharge plans. A facility Consent to Treatment and Conditions of Admission dated 03/16/08, indicated the patient was unable to sign the form due to a diagnosis of dementia. A facility Treatment Authorization Consent form	S 153		

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S 153	Continued From page 2 dated 03/16/08, indicated the patient could not sign the form due to a diagnosis of dementia. An Emergency Nursing Record dated 03/16/08 at 6:25 PM, indicated the patient was seen and treated for a dislocated left shoulder. The patients past medical history included dementia. A facility Physicians Transfer Summary dated 03/17/08, indicated the patient was an 84 year old female who was noted to have frequent falls secondary to dementia. A Discharge Note dated 03/17/08 at 4:10 AM, indicated the patient could be transferred to another facility on 03/17/08 after 6:00 AM. Medicar was arranged to pick patient up and transfer. Facility Transfer Instructions dated 03/17/08 at 5:46 AM, indicated the patient was transferred to another facility. The reason for transfer indicated the patient was stable and needed a lower level of care which would be more appropriately provided at another facility. There was no signature of the patient or the patients representative located on the transfer form that indicated the patient or the patients representative was explained the risks and benefits of the transfer, the location of the transfer or voluntarily agreed to the transfer. The facility Discharge and Transfer Policy revised 01/06, indicated " No patient shall be transferred or discharged solely for the purpose of effecting a transfer to another facility unless arrangements have been made by the patients physician in advance so that such transfer or discharge would not create a medical hazard for the patient, and both the patient and/or the person who is legally	S 153		

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S 153	Continued From page 3 responsible for the patient has been notified or attempts have been made over a 24 hour period prior to the transfer and the legally responsible person cannot be reached." Severity: 2 Scope: 1	S 153		
S 523 SS=D	NAC 449.379 Medical Records 8. All medical records must document the following information, as appropriate: (e) Properly executed informed consent for all procedures and treatments specified by the medical staff, or federal or state law, as requiring written patient consent. This Regulation is not met as evidenced by: Based on interview and record review the facility failed to ensure a properly executed informed consent for a medical procedure on the patient was documented in the patients medical record. (Patient #1) Findings Include: The patient was an 84 year old female admitted through the emergency room on 03/16/08 from an assisted living facility for a dislocation of the left shoulder following a fall. The patient's diagnoses included dementia. An Emergency Nursing Record dated 03/16/08 at 6:25 PM, indicated the patient was seen and treated at the facility for a dislocated left shoulder. The patient past medical history included dementia. On 02/24/09 at 1:10 PM, The Chief Nurse confirmed there was no documented evidence in the medical record that an informed consent for reduction of a dislocated left shoulder under	S 523		

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S 523	Continued From page 4 conscious sedation was signed by the patient or a responsible party prior to the procedure being performed on the patient. The Chief Nurse indicated an informed consent for the procedure should have been obtained by the facility from a responsible family member prior to the reduction of the patients left shoulder under conscious sedation. A facility Consent to treatment and Conditions of Admission dated 03/16/08, indicated the patient was unable to sign the form due to a diagnosis of dementia. A facility Treatment Authorization Consent form dated 03/16/08, indicated the patient could not sign the form due to a diagnosis of dementia. An Emergency Physicians Record dated 03/16/08 at 9:15 PM, indicated the patient underwent conscious sedation with 60 milligrams of Propofol and reduction of a dislocated left shoulder. (No signed informed consent for procedure was located in the medical record) Severity: 2 Scope: 1	S 523		